Case Number:	CM13-0063241		
Date Assigned:	12/30/2013	**Date of Injury:**	03/29/2007
Decision Date:	05/28/2014	**UR Denial Date:**	11/15/2013
Priority:	Standard	**Application Received:**	12/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation has a subspecialty in Pain Management and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient was injured on 03/29/2007. He lifted a connector weighing approximately 200 pounds from a cart to place on another cart and while doing so, he felt a crack in his lower back with pain that traveled to his lower extremities. He suffered an injury to his right shoulder and neck, when the chiropractor lifted his shoulder. Prior treatment history has included physical therapy, medication, and injections; lumbar interbody fusion. Diagnostic studies reviewed include MRI of the right shoulder without contrast performed on 05/08/2013 revealed a tear of the supraspinatus tendon, mild irregularity of the superior labrum without detachment; subacromial spurs were highly associated with superior impingement and degenerative disease of the acromioclavicular joint. MRI of the right shoulder dated 03/22/2013 demonstrated a complete full thickness tear of the mid portion of the supraspinatus tendon; joint effusion extending into the subdeltoid and subacromial bursas; and down sloping of the lateral acromion on the coronal views and a type II lateral acromion. L/S CT dated 12/01/2010 revealed status post laminectomy and posterior instrumentation with anterior bony fusion at the level of L5-S1, the intervertebral graft appeared to be in good position, moderate left neural foraminal narrowing secondary to a posterior protruding osteophyte; a 1 mm diffuse disc bulge at the level of L4-5. Office note dated 10/11/2013 indicated the patient presented with complaints of constant low back pain that varied in intensity and can be very severe at its worse. The pain radiated to his lower extremities, right greater than left. The patient denied numbness in his lower extremities, but stated he had weakness in his legs and feet. The patient stated that his pain level was generally 7-8/10, 0 being no pain and 10 being intolerable pain. He reported his pain was aggravated by prolonged sitting, prolonged standing and personal grooming. His pain was relieved by medication, massaging shower, and hot therapy. The patient complained of constant right shoulder pain described as sharp, burning and throbbing. The pain level was generally 8-

9/10, 0 being no pain and 10 being intolerable pain. The pain was aggravated by elevating his right arm, sudden motions with his right arm and shoulder as well as personal grooming. His pain was relieved by medication, electrical stimulation, physical therapy and pain patches. On examination, he had tenderness in the left testicle but no swelling was appreciated. Deep tendon reflexes were 2+ in the upper extremities bilaterally with good peripheral pulses. There was no pedal edema. The patient ambulated on heels and toes without assistance. There was no evidence of length discrepancies. Cranial nerves II through XII appear intact. His sensation was normal. His shoulder range of motion exhibited Abduction to 90 on the right, 120 on the left; Flexion to 100 on the right, 135 on the left; Internal rotation to 90 bilaterally; External rotation to 90 bilaterally; Extension and adduction to 50 bilaterally. On examination of the lumbosacral spine, he ambulated with wheeled walker. He could walk independently, but he walked slowly with an antalgic and unsteady gait. There was no tenderness and paravertebral muscle spasm throughout the thoracic and lumbar regions. There was a midline scar in the lower lumbar area which was well-healed. Range of motion of the lumbosacral spine revealed flexion to 20; Extension to 0; Right lateral bending to 15; left lateral bending to 15; right rotation to 10; and left rotation to 10. Straight leg raise was positive bilaterally. There was weakness of flexion and dorsiflexion of both feet. There was decreased sensation to light touch over the right C6, C7 and C8 dermatomes; decreased sensation to light touch over the right L5 and S1 dermatomes. The patient was diagnosed with cervical spine sprain/strain; radicular symptoms of the upper extremities, but more on the right side; lumbar spine sprain/strain; radicular symptoms to the lower extremities; history of lumbar spine surgery with residual pain; bilateral wrist sprain; right inguinal area and left testicular pain. The patient stated pain started after lumbar spine surgery; and right shoulder pain-rule out internal derangement. A CT scan of the lumbar spine and a MRI of the cervical spine were requested along with a MRI of the right shoulder and x-rays series of the thoracic spine and both wrists.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

LUMBAR CT SCAN: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304 and Table 12-8.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute and Chronic) CT (Computed tomography).

Decision rationale: As per CA MTUS guidelines, "if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (MRI for neural or other soft tissue, CT for bony structures.) As per ODG, "Magnetic resonance imaging has largely replaced computed tomography scanning in the noninvasive evaluation of patients with painful myelopathy because of superior soft tissue resolution and multiplanar capability. Further, ODG indicates for suspected spine trauma (i.e, fractures, lumbar or cervical), thin-section CT examination with multiplanar reconstructed images may be recommended." In this case, the patient complains of lower back pain radiating to his lower extremities. He was treated with medications, therapy, and had lumbar fusion at L4-5. On physical exam, there is documentation of antalgic and unsteady gait, lumbar tenderness and spasms, decreased ROM, positive SLR bilaterally, weakness of flexion/dorsiflexion both feet, and decreased sensation over right L5-S1. However, there is no evidence of suspicion of

bony abnormalties such as fracture. Also, this patient had prior CT on 12/01/2010 that showed good position of L5-S1 fusion. The request for lumbar CT scan is not medically necessary and appropriate.

MRI OF THE RIGHT SHOULDER: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute and Chronic), Magnetic resonance imaging (MRI).

Decision rationale: As per CA MTUS guidelines, the primary criteria for ordering imaging studies are: Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems), physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon), Failure to progress in a strengthening program intended to avoid surgery, Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). In this case, the patient has already had 2 prior MRIs of the right shoulder on 03/22/2013 and 05/08/2013 that showed tear of the suprasinatus tendon and mild irregularity of the superior labrum without detachment, AC joint degenerative disease, and subacromial spurs. As per ODG, repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The provider has requested MRI of the right shoulder to rule out internal derangement. As per the records submitted for review, there is no indication of worsening or progression of findings that would warrant a repeat study. It is unclear why a repeat study is indicated and thus the medical necessity has not been established. Therefore, the request for MRI of the right shoulder is not medically necessary and appropriate.